PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

ADULT CONSENT FOR VACCINATION

SEASONAL FLU 2014-2015

□ App
□ Walk-in
Time _____

Last Name *(of person receiving vaccination)*:	First Name:	MI:	
Mailing Address:	City	State	Zip Code
Date of Birth:	Age:	□Male □Female □Pregnant _____wks	Phone Number:

Race: (*select one only, for statistical purposes):* □ Not Hispanic/ Latino □ Hispanic/Latino

Ethnicity: (For statistical purposes only. If applicable, you may choose more than one)
□ White □ Hispanic/Latino □ American Indian/Native Alaskan □ Black/ African American □ Asian
□ Hawaiian/ Pacific Islander □ Other →(describe): _____

Insurance:

- Name of Insurance _____ID#_____Group # _____
- Subscriber Name_____ SS#_____DOB_____
- Relationship to Subscriber_____ Subscriber's Employer_____

Note: As a courtesy, we will bill your insurance company. If your plan does not cover Influenza vaccine, You will be billed as the responsible party $25 per flu shot.

☐ I do not have health insurance ☐ I have health insurance that does not cover vaccines

_____I have read or have had explained to me the information contained in the Vaccine Information Statements (VIS) for 2014-2015 about the seasonal influenza vaccine. **I am not sick today, do not have a serious allergy to eggs, and have not had any previous bad reaction to the influenza vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I agree to have Coconino County release my information about this vaccination to the Arizona State Immunization Information System (ASIIS) and other healthcare providers, if requested. (Please cross out this statement if you do not want this information entered into ASIIS.) I understand the benefits and risks of the influenza vaccine and want to receive the vaccine I requested today. If you are billing my insurance, I hereby authorize CCPHSD to furnish information to insurance carriers concerning my visit, and I assign payments for medical services rendered to CCPHSD. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of patient or guardian	Print Name	Date

FOR EMPLOYEE USE ONLY

Clinic Location:_____ Admin Initials*:* _____

PAYMENT DETAILS: *Client may request copy for records. Please ensure all areas are completed for billing purposes.*

☐ Fee Waived ☐ Client Responsible ☐ Bill Insurance ☐ Bill Company _____

Fee/Donation $_____ Form of payment: **Cash** **Check** **CC** Receipt # _____

VACCINATION DETAILS:

Initials	Type of Vaccine	Manufacturer	"VFA"	Lot #	Site	Route	Dose
	Multi Dose	Sanofi			□ LD/ □ RD	IM	0.5ml
	Single Dose	Sanofi			□ LD/ □ RD	IM	0.5ml
	Single Dose	GSK			□ LD/ □ RD	IM	0.5ml
	Multi Dose	GSK			□ LD/ □ RD	IM	0.5ml
	High Dose (65 yrs +)	Sanofi			□ LD/ □ RD	IM	0.5ml

_____

Nurse's Signature **Date**